

# reviews

BOOKS • CD ROMS • ART • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS

## ART

### Exodus

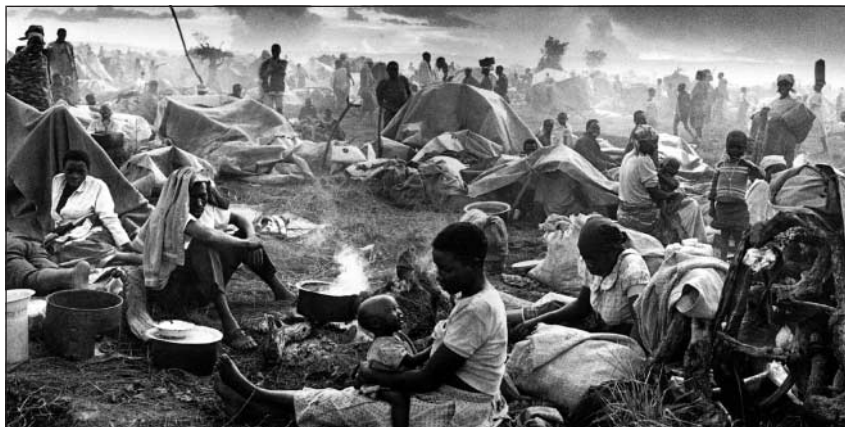
An exhibition of photographs by Sebastião Salgado  
Barbican Gallery, London, until 1 June 2003  
[www.barbican.org.uk](http://www.barbican.org.uk)

Rating: ★★★★★

Amid the xenophobic and hostile debate that hangs like a dark cloud over the treatment of refugees and asylum seekers arriving at British shores comes this timely exhibition. It is a welcome exposé of the intense human suffering such people face in other corners of the world on fleeing their homes, often within the very conflict zones that fuel the global migration phenomenon. And as photographer Sebastião Salgado so aptly notes, "It is a disturbing story."

A Brazilian, who fled to Europe to escape military rule in 1969, Salgado has spent the past few years documenting the lives of populations on the move throughout Asia, Africa, central Europe, and Latin America. His aim: to provoke debate on the human condition and the relentless cycle of displacement and migration, and to ensure that these stateless people are acknowledged and respected.

The underlying theme of many of these images is consistently disturbing and often brutal, despite their artistic quality. Scenes of Rwandan refugee camps in Zaire, 1994—after a genocide that saw the upheaval of hundreds of thousands of people to neighbouring countries—portray images of squalor, death, neglect, and hopelessness.



Tanzania: Rwandan refugee camp of Benako

One image shows a sick man, wide eyed with pain, waiting for free treatment in a temporary Médecins Sans Frontières field hospital in Katala; another, a man dying of cholera face down naked on a dirty floor surrounded by a crowd of onlookers. Grubby, hungry children stare into the lens with blank expressionless faces that say they have seen it all. You are left reeling, overwhelmed with anger that such misery is so ubiquitous, so incomprehensively large scale, and so often tolerated and even ignored by those of us who will never experience anything like it.

I found Salgado's images of Africa particularly depressing and in some instances almost too hideous, and too removed from my own life, to comprehend. Salgado has anticipated such a reaction, perhaps, devoting part of the exhibition to thought provoking images that document the lives of migrants entering the more

developed world. He thereby brings the migration issue to our own doorstep.

Fleeing from war and repression, or to escape a life of abject poverty and limited opportunity, many of those migrants photographed in detention and deportation centres in Malaga, Spain, risk everything to cross the Straits of Gibraltar at night in tiny motorboats from Morocco. Many of them don't make it alive. Those that do face an uncertain future in the face of growing racism and hostility throughout a rich Western world bent on protecting its own interests.

A waiter from El Salvador in a Los Angeles restaurant, a Pakistani shopkeeper in the north of England—they surely deserve our respect, not relentless name calling as scroungers and terrorists. Indeed, such ongoing hostility seems so particularly wrong and ill informed when contrasted against Salgado's images of resilience and courage.

The nature of modern conflicts across the globe ensures that the majority of casualties are civilians, mostly women and children. Thus global displacement looks set to characterise this century as it did the last. As the aid community now braces itself for an increase in internally displaced people and refugees attempting to cross the Iraqi border into Turkey, Iran, Syria, and Jordan as the bombs drop on Iraq, you are left wondering whether there will ever be a way out of the cycle of human despair this exhibition encompasses. How long can we remain as informed spectators on the sideline watching such tragedy unfold before our eyes?

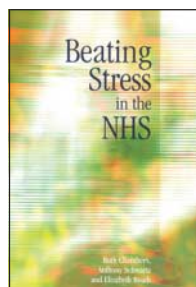
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Hong Kong: detention centre for refugees from South Vietnam

# Beating Stress in the NHS

Ruth Chambers, Anthony Schwartz,  
Elizabeth Boath



Radcliffe Medical Press,  
£24.95, pp 168  
ISBN 1 85775 927 3

Rating: ★★

**B**orrowing techniques from therapy and life coaching, this book offers stress reduction remedies, resources, and encouragement. It is visually appealing, with cartoons, bulleted checklists, and boxed exercises breaking up short chunks of text.

Reading this book won't change your life. Completing the exercises, learning new techniques, and implementing them may well do, but it requires a huge commitment: "It may take a year or more to try out the different ideas," the authors warn.

The first chapter is gloomy: the NHS has changed; expectations are high; rewards are low; staff are not valued; consultants' morale is lower than ever; nurses are leaving. The NHS is alleged to be a source of stress and those working in it are instructed to look after themselves before they can look after others.

*Reducing Stress in the NHS* has been designed to be read and followed chapter by chapter. It identifies psychological hazards intrinsic to the NHS and encourages readers to keep a record of daily stressors and their responses to them. Other exercises include constructing activity maps and keeping a daily record of "negative internal thoughts that need turning around."

The book offers ambitious tips for stress management of a whole team. It suggests

that colleagues form self help groups, and gives advice on conducting a workplace stress risk assessment and designing and implementing a team stress management policy.

I attempted an exercise on identifying workplace stresses but the form was too small and trying to enlarge it on the photocopier gave me a tension headache. And as for keeping a daily work stress log, if you really had time to fill in the forms at work, you could probably skip the time management exercises.

This book is aimed at stressed NHS workers who want to cope better but don't know where to start. Because of the time, energy, and enthusiasm needed to complete the workbook, I suspect it will appeal most to those needing it least.

**Sabina Dosani** specialist registrar in child and adolescent psychiatry, Maudsley Hospital, London  
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## When Jessica died

A teenager's death has highlighted medical errors and transplant problems in the United States

**S**unday 16 March was a bad media day for American medicine—a really bad day, considering it came during annual Patient Safety Week.

The popular CBS investigative programme *60 Minutes* broadcast "Anatomy of a Mistake," detailing the simple error that killed transplant patient Jessica Santillan. The *New York Times* headlined its Sunday magazine "Half of what doctors know is wrong" and devoted the issue to "exploring medicine and its myths."

Coming on the same day and reaching millions, these two events may be a watershed in focusing public attention on the related problems of medical errors, transplant mistakes, and the malpractice mess.

Just four days later, on 20 March, the *New England Journal of Medicine* published a damning Perspective article about the Jessica Santillan case entitled "A Death at Duke" (*NEJM* 2003;348:1083-4). It said, "When a medical mistake receives this much attention, it affects the medical profession and even public policy."

Jessica was a 17-year-old Mexican girl with congenital restrictive cardiomyopathy. Her parents had the family smuggled into the United States to find her a heart-lung transplant. They moved to Durham, North Carolina, home of Duke University Medical

Center, one of America's best. They lived in a trailer and begged on the streets to raise money for her transplant. A local businessman started a foundation to help. Jessica was put on the transplant list at Duke. She waited three years until a donor was found.

On 7 February surgeon James Jagers had almost completed the operation when he learnt that the organs came from a donor with type A blood, incompatible with Jessica's type O. The story became front page news. Jessica was kept on life support systems while a second transplant was sought—and, astonishingly, found. Despite the second transplant, Jessica died from irreversible brain damage on 22 February.

The *60 Minutes* presenter Ed Bradley asked, "How did an operation performed by a team of expert surgeons go so wrong? What it came down to was a failure to communicate basic information. Not one of the more than a dozen people working at Duke Hospital and the two organisations responsible for getting the new heart and lungs to Jessica Santillan ever cross-checked her blood type before the surgery to see if it was a match with the blood type of the donor."

Jessica's story was followed in the national news by a Texas lawsuit. A 17 month old girl died after receiving a partial liver transplant from her father, who was incompatible, instead of from her mother, who was compatible. Apparently a laboratory mixed up the results of blood typing on the girl's parents.

The day of the *60 Minutes* report, the *New York Times* Sunday magazine included an article: "The Biggest Mistake of Their Lives. What is it like to be the survivor of a medical error? Four patients speak about the operations that divided their lives into before and after." Two patients had gauze or an instrument left behind. Both required further surgery, losing time from work, and one was permanently disabled. Another

patient underwent radical, disfiguring jaw surgery after a misdiagnosis of cancer. In the fourth case, a man's kidney transplant from his sister failed because it was put in on the wrong side. He was forced on to dialysis and could not continue in his job, which required travel.

Three years ago the Institute of Medicine report *To Err is Human: Building a Safer Health System* (Washington, DC: National Academy Press, 2000) called for no-fault reporting of medical errors and "near misses," so that problems could be corrected instead of trying to find someone to blame. Such systems are used in the airline industry.

Doctors have complained about skyrocketing insurance premiums, which they say are caused by huge jury awards in malpractice cases. President George W Bush strongly supports limits on jury awards. On 13 March the Republican-controlled House of Representatives passed legislation limiting non-economic damages, such as those for pain and suffering, to \$250 000, despite testimony by victims such as a woman who had a double mastectomy because of a mix-up in pathology reports. The limits would apply to doctors, hospitals, nursing homes, and other providers of health care. Patients who are harmed could still sue for lost wages or the cost of medical care to treat the injury. The House also passed a bill creating a voluntary system to report medical errors, but opposition Democrats said it lacked teeth for enforcement.

A bill limiting malpractice awards is being considered in the Senate, its chances weakened by stories like Jessica's. If the bill is passed, few lawyers would take Jessica's case, since there were no economic damages—she did not hold a job. Litigation would be costly, even though the Senate may raise the maximum award to \$500 000.

**Janice Hopkins Tanne** medical journalist, *New York*





## MMR: the onslaught continues

**T**he controversy surrounding the measles, mumps, and rubella (MMR) vaccine continues to smoulder and every now and then someone stokes the fire. This time it is "top *Mail* writer" Melanie Phillips in a much hyped series of three articles in the *Daily Mail* under the banner "MMR: the truth" (11, 12, and 13 March).

Despite a three month globe-trotting investigation, Phillips, a seasoned polemicist, presents nothing new; she simply follows the usual pattern of conspiracy theory. For example, she claims that Professor John O'Leary, a pathologist at Trinity College Dublin, was gagged after announcing that the measles virus he had found in the guts of children with autism was the same strain as that used in the MMR vaccine. And she refers to more "potentially explosive" about-to-be-published research from gastroenterologist Andrew Wakefield—"the doctor at the heart of the MMR furor"—which it is claimed will show that he is right and that the rest of the world is wrong.

Phillips' articles, billed as a "major new series," follow the special MMR theme issue published last year by the satirical magazine *Private Eye*, which also appeared to have

taken on board unthinkingly all that Andrew Wakefield has said, and lacked any scientific underpinning (*BMJ* 2002;324:1224).

In a similar fashion to the *Private Eye* "exposé," Phillips consistently describes the experts in the "anti-MMR camp" in glowing terms, such as "eminent," "renowned," and "foremost." However, she is less liberal with her superlatives in describing the "pro-MMR" experts.

She describes Wakefield as an outcast and an enemy (of the scientific community and the government), who believes himself to be on the brink of vindication. Unfortunately, appealing to the public through a writer like Melanie Phillips, rather than by subjecting his findings to the usual scientific peer review process, will only cause further anxiety and concern for parents and do nothing to win the hearts and minds of the scientists.

Phillips makes much of the conflicting interests of various experts. She rightly points out that vaccine manufacturers have employed some "pro-MMR experts" as advisers or have funded them in their research. But surely it is reassuring to know that the companies seek advice from people who know what they are talking about? Authors in most mainstream journals, including the *BMJ*, are required to declare any potential conflicting interests; if they sit on government committees discussing vaccines, they do not take part in discussions that may conflict with these interests.

However, Phillips does not point out that Andrew Wakefield and other players are acting for the parents in an upcoming court case over MMR and so could be said to have vested interests. Just as we ought not to



"MMR: the truth" presents nothing new

ascribe venal motives to the parents of autistic children who would stand to receive compensation if their lawsuit succeeds, so we should not accuse researchers of bias because vaccine manufacturers fund their research. If everyone with an "interest" were to be removed from the debate there would be no one left with any knowledge of the subject.

Phillips rubbishes epidemiological studies, even though such studies have been the tools used in many major medical discoveries, such as the link between smoking and lung cancer. The reviews she quotes have quite correctly concluded that the evidence does not support a link between autism and MMR, but it can never rule out the possibility that the occasional case is associated with the vaccine. Phillips interprets this as distortion, which demonstrates her lack of understanding of one of the fundamental tenets of epidemiological research—that one can never totally prove a negative. However, she refers to an "epidemic of autism." If there is one, then epidemiological studies should have no problem in picking up a major factor in its causation.

In place of epidemiological studies, Phillips calls for clinical studies, involving talking to parents and examining individual children. Why this should be better is unclear and reveals a lack of understanding that one always has to compare affected children with those who are unaffected. Without this, there can be no useful progress and, more likely, there is a serious risk of drawing the wrong conclusions, as was the case with the whooping cough vaccine.

The *Daily Mail*'s series of articles will serve only to worry parents further. Researchers, and those who report their work, must consider the effect that anything they say may have, especially when it comes to the health of children. This responsibility should not be taken lightly.

**Helen Bedford** lecturer in child health, Institute of Child Health, London

**David Elliman** consultant in community child health, St George's Hospital, London

Both authors have received funding from vaccine manufacturers as well as other sources to attend educational meetings and conduct research.

Another review of the *Mail* articles can be found at [www.spiked-online.com/Articles/0000006DCD6.htm](http://www.spiked-online.com/Articles/0000006DCD6.htm)



## WEBSITE OF THE WEEK

**Doctors' wellbeing** In a demanding profession like medicine, work related stress is neither something to be ashamed of nor a sign of incompetence. It just requires the right approach. A special issue this week of *BMJ Careers* focuses on wellbeing, offering advice on stress management (p s107), as well as guidance for ill doctors (p s103), and tips for maintaining wellbeing (p s109).

Readers may also look to the internet for help. Heal Thyself ([www.healthyselfprograms.com](http://www.healthyselfprograms.com)), a US affiliation of practitioners and teachers, runs several programmes in the United States designed to enhance doctors' health, wellbeing, and stress management skills. Tackling problematic medical marriages, increasing relaxation and recreation for the clinician, and providing the opportunity to rethink careers are among the programmes on offer. The drawback with these programmes is that doctors cannot participate online, which implies that only US doctors have real access to them.

For doctors who want to rediscover or strengthen the satisfaction of practising medicine, the US Institute for the Study of Health and Illness has a solution ([www.meaninginmedicine.org](http://www.meaninginmedicine.org)): start or join a Finding Meaning in Medicine (FMM) group. "We have found a simple form of group process that enables us to listen deeply to one another, rediscover the joy of our work and receive the kind of healing that only fellow physicians can bring to one another," says the site. The process is said to be simple and to require little effort. Just register and you can access the resource guide for doctors who wish to start an FMM group in their communities. The site also hosts an online group with a new topic every month.

UK doctors dealing with difficulties arising from job stress or illness can find help—and links to other sources of possible help—from the Doctors' SupportLine website ([www.doctorsupport.org](http://www.doctorsupport.org)) and the National Counselling Service for Sick Doctors ([www.ncssd.org.uk](http://www.ncssd.org.uk)).

**Irina Haivas**  
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# PERSONAL VIEW

## Never say die

This year is one of celebration in my family. My daughter, who nearly died from anorexia, is making a steady recovery. The reasons for the illness are complex and may never be fully understood, but I will always feel that my dedication to a career in medicine and my commitment to the NHS were, in part, to blame.

Anorexia is a frightening illness. It creeps up insidiously, and, even when it is staring you right in the face, you deny its existence. A letter came, anonymously from two school friends: "We are so worried. E is eating a slice of melon and going for a long run. She cannot go on like this." She is, at this stage, on top of the world, her worries are suppressed by her control over her weight, she is oblivious to the danger, and she has controlled her overwhelming hunger. When challenged she laughs, says she is fine, and carries on eating next to nothing.

Realisation dawns that telling her to eat and pointing out the dangers of starvation are not going to produce any response. Her general practitioner and friends fail dismally as well.

Her body mass diminishes; at any moment she will start to digest her own heart.

It is not easy to gain access to specialist care. E was eventually forced to enter an inpatient unit. She wept and screamed, and I wept, too, and wished that I could scream. As her weight increased her anxiety and anger returned, and she ran away from the unit. Anorexia triumphed; they could do no more. A nurse said, "I think E will get better, but not here." The books told me that a third of people with anorexia die, a third become chronically ill, and a third recover. I could see only the first outcome.

E was transferred to the eating disorders unit at the Bethlem Royal Hospital. The regime there is of international repute. It consists of feeding large quantities of high calorie food on the basis of peer pressure. If the girls refuse to eat, all their friends will be given a high calorie drink, and they will have to eat more next time. It is combined with "family therapy," usually as part of a research study. This is conducted by a senior nurse and a highly trained social worker. Parents are invited to a monthly "ward round," where about 16 people involved with their daughter's care sit round a room with the consultant to discuss progress, or lack of it. It

## I had to apologise for my own career and commitments

was not an environment conducive to expressing one's innermost feelings. We were not blamed for the illness, although I had to apologise for my own career and commitments. I was a marked woman—one who had repeatedly left her children in the hands of strangers.

E gained weight, abused laxatives, and, after six months, convinced a tribunal that she should be discharged. She returned home that evening, but rapidly lost weight and had to be resectioned. At this stage there was no therapeutic rapport with the unit. Anorexia had triumphed again.

After another six months of hopelessness, we insisted that she came home. It was her 19th birthday. She looked happy, but was very thin. In four weeks she was unable to move, was very weak, and stopped drinking. After a struggle, I mobilised the local forces to section her again. A phrase in a book kept coming back to me: "However desperate the situation, recovery is possible. Never say die." There was no NHS bed and E was admitted to a private eating disorders unit in London. Her body mass index was 9.

There followed six months of negotiation between E and the staff. She was fed slowly and gradually, with foods that did not frighten her. Her laxatives were stopped; there was no one to buy them. She paced up and down all day, wearing out her feet and shoes. One of us visited every day, she would talk as she walked in the garden, and this time some of the talk was optimistic—a sign that she could come back to life. She made friends, she had choices; we were not blamed for being what we are.

In August last year our daughter started to come back to us. She began to speak about her feelings, her hopes, and her fears; she planned extravagant holidays to exotic islands; she expressed a need for our love, and began to accept it. She has begun to make friends outside the hospital and has dared to tell them about her illness; she has been wonderfully supported by her younger sister. She takes driving lessons and has just returned to part time studies.

Has my career been one of the causes of her illness? I now think not the career itself, perhaps, but the emotional restraint of being a professional, putting the needs of patients before those of family, being too tired to talk, the belief that one can do it all. It is not possible.

But we are still a family.

**Joan Hester** consultant in pain medicine, East Sussex Hospitals NHS Trust

E has given her consent for this article to be published

# SOUNDINGS

## Bag of bones

Whenever a new patient joins the practice I look through the chart from back to front. When read in chronological order a chart becomes a kind of storybook, so it's less like real work (although if a chart consists of more than five volumes, I speed read).

The charts tell us as much about the changing nature of medical practice as they do about the patients. The old GP notes are terse but colourful one liners—"swinging the Pb"—and the old dog eared hospital letters are full of value judgments and sarcasm—"This patient came in on crutches; I relieved him of them and sent him on his way."

Nowadays GP notes are rather obsessively comprehensive and hospital letters objective and cold, both perhaps lacking in nuance and a mite less informative than before. Each life unfolds in leaps and starts. Plenty of notes on childhood infections, then a big gap, interrupted for women by the pleasant meadows of fertility and childbearing.

Some people are unlucky to be struck by early illness, asthma, inflammatory bowel disease, or depression, but for most of us the chart remains thin and sketchy till we reach the 40s. Then the first pale intimations of mortality start, dim drums throbbing in the hills half heard. Minor harbingers of doom start to appear—hypertension, osteoarthritis, gratuitous counselling—and from then on the entries and reports multiply. Sickness piles on sickness, cancer piles upon degenerative disease, piles pile upon piles, like Pelion on Ossa, as this is one storybook that will not have a happy ending and with each page the grave yawns a little wider (and gives the occasional burp).

But comprehensive as they may be, the clinical notes tell us little about the real person. And why should they? It's none of our business. Thomas Hardy once referred (I am quoting Stephen King on this, and I presume he wasn't making it up) to the futility of fiction. "Compared to the dullest human being walking on the earth," he apparently said, "the most brilliantly drawn character in any novel is but a bag of bones." And that from the creator of the magnetic Giles Winterbourne.

This limitation is absolutely fine by me. Doctors don't need to know everything and there are some things that are best undisclosed in our bag of bones: we all have a few skeletons in our cupboard.

**Liam Farrell** general practitioner, Crossmaglen, County Armagh

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